as perceived by traditional and faith-based healers in Korail slum. We attempted to unravel the nuanced approaches the healers use to distinguish spiritual afflictions from psychiatric conditions and to explore potential collaborations between traditional healing practices and biomedical mental health services as a part of TRANSFORM Research.

Methods. Adopting an ethnographic and participatory approach, this study engaged in a comprehensive qualitative exploration involving community engagement meetings, 45 key informant interviews, 8 naturalistic interviews with 56 participants, year-long observations of the community and healing practices, 5 co-designing workshops with 46 participants, and 2 pilot training programmes from 2021 to January 2024. We discussed with the traditional and faith-based healers, community health workers, medicine sellers, person with lived experience and their caregivers. The continuous discussion and observation of the community help us to develop a trusted relation and explore the healing practices in the korail slum. Data collected from interviews and workshops were meticulously transcribed and analysed using NVivo software to uncover underlying patterns and distinctions made by traditional and faith-based healers in diagnosing Jinn Possession versus serious mental disorders.

Results. We found a stepwise diagnostic framework utilized by healers, initially categorising conditions based on the symptom's onset and presentation. Sudden and rapid symptoms onset, especially during specific times of the day, was often attributed to Jinn Possession. Specific symptoms such as sudden onset convulsions, disorganised speech and self-laughing further supported this distinction. Moreover, they used traditional diagnostic tests, including the use of holy water and recitation of the Quran, if the patient improves immediately following these interventions was considered as confirmation of Jinn Possession. We observed a few of the healers refer cases perceived as non-spiritual to biomedical facilities when they confirmed it was not the case of Jinn Possession, indicating a potential for collaborative mental health-care models

Conclusion. This cultural understanding offers a unique perspective on community-based mental health care in Bangladesh, emphasising the importance of integrating traditional and biomedical approaches to foster a more inclusive and culturally sensitive mental health-care ecosystem.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Acute Cardiac Care for People With Severe Mental Illness Following a Myocardial Infarction Among People With a Severe Mental Illness: A Qualitative Study

Dr Amanda Vettini[1]*, Dr Debbie Cavers[1], Professor Sandosh Padmanabhan[2], Prof Daniel Smith[1] and Dr Caroline Jackson[1]

[1]University of Edihnburgh, Edinburgh, United Kingdom and [2]University of Glasgow, Glasgow, United Kingdom
*Presenting author.

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Aims. To understand the challenges and barriers experienced by health-care professionals (HCPs) in providing acute cardiac care to patients with severe mental illness (SMI) (schizophrenia, bipolar disorder or severe depression) admitted to hospital following a myocardial infarction (MI).

Methods. Semi-structured 1:1 videocall interviews with 12 HCPs in two central-Scotland Health Boards involved in delivering pre-/hospital acute care for a MI (paramedics, cardiology/A&E nurses, cardiology/A&E doctors). Interviewee recruitment was via clinical and research networks and newsletters e.g. the Scottish Ambulance Service, the Royal College of Nursing and Royal College of Physicians and through professional connections. Interviews were audio-recorded, transcribed verbatim and analysed thematically drawing on Braun & Clarke and using NVivo software.

Results. HCPs identified a number of challenges/barriers to providing optimal post-MI acute cardiac care to patients with a SMI across 3 key themes: patient-related; practitioner-related and system/environment-related. Core patient-related challenges/barriers included: diminished patient history capacities especially relating to chronology; the time-consuming nature of effective HCP-patient communication and engagement; medication and intervention concordance concerns and challenging patient behaviour including physical and verbal aggression or severe distress.

Practitioner-related challenges/barriers were: fears of appropriately managing patient behaviour; stigma towards patients with a SMI (putatively arising from knowledge deficits or generational/age-related effects); staff burnout due to length of service and pressures from extreme workloads.

Systemic issues included insufficient staffing precluding the additional time required for effective communication and the distressing nature of hospital environments for patients with a SMI. Side rooms were not routinely available even though these were identified as improving the environment for some patients. A core systemic finding, cited by all interviewees, was the lack of adequate training provision on caring for patients with a SMI. Additional system-level findings were degrees of challenges accessing input from the hospital psychiatric team especially outwith standard hours and problems obtaining rarer psychiatric medications potentially impacting patients' mental health stability.

Positive findings included that HCPs are generally enthusiastic about providing high quality care to this patient group and to seek help with this. Some HCPs indicated that caring for mentally stable patients with a SMI does not differ from the general population.

Conclusion. Although HCPs aspired to providing optimal acute cardiac care for this patient group, patient-level, professional and systemic barriers often make this challenging. A key area for improvement is enhancing staff training in caring for patients with SMI, ideally delivered in-person.

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The Social and Clinical Factors Associated With Mental Health Act (MHA) Use Among Children and Adolescent Inpatients: A Cohort Study Using Electronic Health Records

Dr Susan Walker[1]*, Dr Daniela Fonseca Freitas[2,3], Dr Johnny Downs[4], Mr Patrick Nyikavaranda[5] and Professor Sonia Johnson[1]

[1]Division of Psychiatry, University College London (UCL), London, United Kingdom; [2]Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, United Kingdom; [3]Department of Psychiatry, University of Oxford, Oxford, United Kingdom; [4]Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, United Kingdom and [5]Department of Primary Care & Public Health, Brighton & Sussex Medical School, University of Sussex, Brighton, United Kingdom
*Presenting author.

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